U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 April 2007

Case No. 2004-BLA-6134

In the Matter of

C. W.,

Claimant,

v.

GREEN RIVER COAL CO.,

Employer,

and

SECURITY INSURANCE CO. OF HARTFORD,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

Thomas W. Moak, Esq.
Moak & Nunnery
Prestonsburg, Kentucky
For the Claimant

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing or participate in this case after referral to this office, the Director is deemed to have waived any issues which it could have raised at any stage prior to the close of this record. By referring this matter for hearing the District Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

Lois A. Kitts, Esq.
Baird & Baird, PSC
Pikeville, Kentucky
For the Employer

BEFORE: LARRY S. MERCK
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On April 19, 2004, this case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs for a hearing. (DX 37).[2] A formal hearing in this matter was conducted on June 28, 2006, in Pikeville, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "TR" refers to the transcript of the hearing.

[3] At the hearing, Employer withdrew the following issues as set forth on Form CM-1025: miner (Issue #2), post-1969 employment (Issue #3), responsible operator (Issue #12), and the most recent period of cumulative employment of not less than one year (Issue #18A). (TR 11-12). Employer and Claimant also stipulated to at least fifteen years of coal mine employment. *Id.* Because this claim was filed more than one year after the disposition of Claimant's previous claim, this is a subsequent claim, although the parties did not indicate this was an issue. (Issue #14 on CM-1025). Employer also maintains constitutional issues for appeal purposes only.

2. Whether Claimant has pneumoconiosis as defined in the Act and regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

5. Whether Claimant's disability is due to pneumoconiosis; and,

6. Whether the evidence establishes a material change in condition per § 725.309(d).

(TR 11-12; DX 37).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

Claimant, C.W., was born on April 15, 1939. He completed the sixth grade. (DX 1, 3; TR 14). He is married and had one dependent child at the time he filed his subsequent claim. (DX 3, 11, 20; TR 25-26).

At the hearing, the parties stipulated to at least fifteen years of coal mine employment. (TR 11-12). Claimant is not the best historian of his coal mine employment. After reviewing the evidence of record to include Claimant's Social Security earnings statements and W-2's submitted with this case, I find that Claimant's last coal mine employment was with Green River Coal in 1988. (TR 14; DX 3, 8, 20). Claimant worked as a general inside laborer performing various jobs, but most of his time was spent roof bolting and maintaining the ventilation in the mines. (TR 14-15; DX 4, 20). These jobs required bending, pushing, pulling and heavy physical work. (TR 14-17). His work schedule at Green River was typically eight hours per day, six days a week. (DX 20). Claimant stated that he was exposed to significant amounts of coal dust in the aforementioned jobs. (TR 16-17). Claimant has not worked anywhere after being laid off from Green River Coal when it shut down its mine in 1988. (TR 23; DX 3, 8, 20).

Claimant is treated by Dr. George Chaney and Claimant sees about every two or three months. (TR 18; DX 20). He is prescribed several different medications for his breathing problems and is on oxygen twenty-four hours a day. (TR 18). He also uses an inhaler and nebulizer. (TR 21). Claimant testified that he is short of breath and often feels like he is smothering. (TR 17-18). He cannot climb stairs or walk very far and can no longer hunt or fish. (TR 18; DX 20). He cannot sleep for more than one hour at a time because of his breathing problem and sleeps on a raised hospital bed. (TR 27). He has a productive cough and was hospitalized several times for his respiratory problems. He also takes medication for high blood pressure. (DX 20; EX 12).

The record contains varied statements regarding Claimant's smoking history. Claimant testified that he smoked about one-half pack of cigarettes a day for about fifteen years. (TR 19-20). However, he also stated he has not smoked "regularly" for over ten years. He never smoked in the mines. (TR 20; DX 20). Dr. Rosenberg in his medical report, dated August 31, 2004, recorded a smoking history of three years, quitting thirty years ago. (EX 1). Dr. Fino in his consultative medical report, dated August 1, 2005, noted a twenty year smoking history, quitting in 1964. (EX 6). In his progress notes from 2002, Dr. Chaney reported that Claimant was a "former" smoker, but in all of his notes from 2005 and 2006, this doctor indicated Claimant was a "current" smoker and advised his patient to avoid cigarettes. (EX 12). Dr. Baker in his medical report, dated December 2, 2002, reported around a twenty year smoking history at the rate of one pack of cigarettes per day, quitting when Claimant was age thirty-five. (DX 13). Dr. Forehand in his medical report, dated August 25, 2004, recorded a four year smoking history, quitting in 1974. (CX 2). In weighing the evidence regarding Claimant's smoking history, I find that the evidence is contradictory; and therefore, I am unable to make a finding as to his smoking history.

Claimant filed his first application for benefits with the Social Security Administration on May 21, 1973. (DX 1). This claim was eventually denied by a Claims Examiner on May 14, 1980, who determined that Claimant had not proven any of the medical requirements to qualify for black lung benefits. *Id.* Claimant did not appeal this decision and the first claim was closed.

Claimant filed his second application for benefits on September 13, 2002. (DX 3). The District Director issued a Proposed Decision and Order denying benefits on December 17, 2003. (DX 31). The matter was transferred to this office after Claimant submitted a request for a formal hearing conducted by an Administrative Law Judge. (DX 33, 37).

Length of Coal Mine Employment:

The parties stipulated to at least fifteen years of coal mine employment. (TR 11). After reviewing the Claimant's statements, his testimony, the Social Security earnings statement and W-2's submitted with the claim, I accept the stipulation and credit Claimant with at least fifteen years of coal mine employment. (TR 14-16, 23; DX 3-6, 8, 20, 30).

Timeliness:

Employer contests the timeliness of this claim on the basis that it was not filed within three years of Claimant being informed that he was disabled due to pneumoconiosis, as required under the regulations. § 725.308. The current claim was filed on September 13, 2002. Employer contends that Claimant became aware that he was totally disabled due to pneumoconiosis in 1998 when a physician "did not pass him for coal mine work." This occurred when Claimant applied for a coal mining position with Leeco. (Employer's post-hearing brief, p. 26). Employer also argues that Claimant was made aware of his disability due to pneumoconiosis when the Kentucky Workers' Compensation Board awarded him benefits for total occupational disability from pneumoconiosis in 1978. *Id.*

Claims for benefits under the Act are accorded a statutory presumption of timeliness. § 725.308(c). A claim is timely filed if it was filed before three years after a "medical determination of total disability due to pneumoconiosis" is communicated to the miner. § 725.308(a); 30 U.S.C. § 932(f). It is Employer's burden to rebut the presumption of timeliness by showing that a medical determination satisfying the statutory definition was communicated to the miner three years prior to the date of his subsequent filing. *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 607 (6th Cir. 2001). In this case, the date of Claimant's subsequent filing was September 13, 2002. In *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004)(unpub.), a case arising within the Sixth Circuit, the Board concluded that "the administrative law judge must determine if (the physician) rendered a well-

reasoned diagnosis of disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

In *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), the court held that under § 725.308(a), the statute of limitations for filing starts after each denial of a previous claim, provided that the miner returns to coal mine employment for a substantial period of time after the denial and a new medical opinion of total disability due to pneumoconiosis is communicated. *Sharondale*, 42 F.3d at 996. The court declined to hold that the statute of limitations only applied to the filing of initial claims. *Id.* "[F]or the Act to recognize serial applications on the one hand, while limiting to three years the time in which all applications must be filed, makes no sense." *Id.*

The Sixth Circuit further defined the application of § 725.308 in *Kirk*. The *Kirk* court held that:

> [t]he three-year statute of limitations clock begins to tick the *first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination . . . and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period.

264 F.3d at 608. The Sixth Circuit stated that Kirk's three prior denials did not trigger the statute of limitations because they were premature filings, noting that previous medical opinions did not conclusively opine that Kirk was totally disabled due to pneumoconiosis. The Board has also addressed this issue, in *Bowling v. Whitaker Coal Corporation*, BRB No. 04-0651 and 04-0651 (April 14, 2005), when it remanded the claim

for reconsideration of the timeliness issue, quoting the instruction in *Sharondale* that an Administrative Law Judge must decide whether the record contains a "medical determination of total disability due to pneumoconiosis which has been communicated to the miner."

In this case, Employer presents convincing evidence that Claimant believed he was totally disabled due to pneumoconiosis in 1978. However, Employer has failed to meet the first prong of the two-part test under § 725.308, by presenting medically supported and reasoned opinions that establish Claimant was actually totally disabled due to pneumoconiosis at the time. Claimant's testimony was that a doctor did not pass him for work with Leeco, but Claimant could not even recall the doctor's name, and the particular physician's report to which he refers was never made part of the record. (DX 20, p. 13). Dr. Chaney's progress notes do not report that Claimant is or ever was totally disabled due to pneumoconiosis. Dr. Bushey's report in 1976 lists a diagnosis of pneumoconiosis, but Dr. Bushey does not offer an opinion surrounding Claimant's ability to return to his coal mine job. In 1977, Dr. Martin recommended that Claimant should not return to underground coal mining, but only refers to an x-ray, without providing any other basis for his opinion. (DX 1).

In considering this evidence pursuant to § 725.308, the Sixth Circuit's holding in *Kirk*, and the Board's decision in *Bowling*, I find that Employer has failed to satisfy the first requirement under § 725.308, that a reasoned, probative, documented, and written medical report be of record stating that Claimant was totally disabled due to pneumoconiosis. Because Employer did not offer any evidence that a well-reasoned and well-documented diagnosis of total disability due to pneumoconiosis was communicated to Claimant, I find that Employer did not rebut the presumption that this claim was timely filed.

Applicable Regulations:

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. Amendments to the Part 718 regulations became effective on January 19, 2001. As this claim was filed on September 13, 2002, such amendments are applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide

that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to similar limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii).

Subsequent Claim:

Section 725.309(d) provides that a subsequent claim must be denied unless Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. § 725.309(d)(2). If Claimant establishes the existence of one of these conditions, he has demonstrated, as a matter of law, a material change. If he is successful in establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

The initial claim was denied when it was determined that Claimant failed to establish any of the medical requirements to entitle him to black lung benefits. (DX 1). In the current claim, the District Director concluded that Claimant established total disability. (DX 31). As is discussed later in this Decision and Order, I have found that Claimant established total disability in his current claim. Accordingly, I must review the entire record to determine if Claimant establishes pneumoconiosis, pneumoconiosis arising out of coal mine employment, total disability, and total disability caused by pneumoconiosis.

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to §

718.202, the Claimant can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in §§ 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under § 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with § 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

The first new x-ray interpretation was submitted by the Director and is a reading by Dr. Baker, a B-reader.[4] (DX 13). Dr. Baker read this film, dated December 3, 2002, as showing a profusion of 1/0. Dr. Barrett, a Board-certified Radiologist and B-reader, re-read the x-ray for quality purposes only, finding it to be of the highest quality. (DX 14). However, this x-ray was re-read by a Board-certified Radiologist and a B-reader, Dr. Wiot, as negative for the disease. (DX 17; EX 14). Therefore, assigning the most probative value to the highest-qualified reader, I find this film negative for the existence of pneumoconiosis.

Claimant submitted two x-ray interpretations in support of his position, which is within the statutory limits. One reading was by Dr. Sundaram of an x-ray dated January 18, 2002, and he found this film positive for pneumoconiosis with a profusion of 2/2. (DX 18). However, Employer submitted a rebuttal reading of this x-ray by Dr. Wiot, a Board-certified Radiologist and a B-reader, who found no evidence of pneumoconiosis. (DX 19; EX 14).

[4] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).

Therefore, assigning the most probative value to the highest-qualified reader, I find this film negative for the existence of pneumoconiosis.

Claimant's second reading was by Dr. Forehand, a B-reader, who reported pneumoconiosis with a profusion of 1/0 on a film dated August 25, 2004. (CX 2). Dr. Wiot, a Board-certified Radiologist and a B-reader, re-read this film as negative for the disease. (EX 11, 14). Therefore, assigning the most probative weight to the higher-qualified reader, I also find this film negative for the existence of pneumoconiosis.

Employer submitted two x-ray interpretations as its affirmative evidence. Dr. Rosenberg, a B-reader, interpreted a May 1, 2003, film as negative for pneumoconiosis. (DX 16). Dr. Rosenberg also interpreted a film dated August 11, 2004, as negative for the disease. (EX 1). No rebuttal evidence was offered in response to these two readings. Therefore, I find they are negative for pneumoconiosis.

Claimant also submitted, with Dr. Forehand's medical report, an additional positive reading of the Director's film dated December 3, 2002. (CX 2). However, as this exceeds the statutory limitation for Claimant's affirmative evidence, it will not be considered. (CX 4). Likewise, Employer's x-ray interpretation of this same film, submitted as "rehabilitative" evidence on Employer's Evidence Summary Form, will not be considered, because it is in excess of the rebuttal limitations and is not a "statement" by the physician who "originally interpreted the x-ray" as required under § 725.414(a)(3)(ii). (EX 4, 15).

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist). In this case, all five x-rays were interpreted as negative by the most highly qualified physicians. It is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990). The United States Court

of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. *Stanton v. Norfolk & Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993)). Accordingly, based on the preponderance of negative readings by the most qualified physicians, Claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. § 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

Under § 718.202(a)(4), the fourth and final method to establish pneumoconiosis, a determination of the disease may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive

> pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a).

This subsection provides for such a finding of pneumoconiosis where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Field v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.*

Dr. Glen Baker, Board-certified in Internal Medicine and Pulmonary Diseases, physically examined Claimant on December 3, 2002. (DX 13). His medical workup included a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. Dr. Baker recorded that Claimant worked in underground mine employment for twenty-three years and smoked one pack of cigarettes a day from age fifteen or sixteen to age thirty-five. He stated that Claimant suffers from sputum production, daily wheezing, dyspnea, cough, orthopnea, and ankle edema. Claimant's EKG was normal. Under x-ray findings, Dr. Baker noted coal workers' pneumoconiosis category 1/0. His pulmonary function study revealed a "severe obstructive defect." However, the administering technician stated "question maximum effort[,] tracings were not reproducible." The arterial blood gas analysis showed a "mild resting arterial hypoxemia." Dr. Baker made the following diagnosis: 1) coal workers' pneumoconiosis 1/0 – based on an abnormal x-ray and coal dust exposure; 2) chronic obstructive pulmonary disease ("COPD") – based on pulmonary function tests; 3) chronic bronchitis - based on history of cough sputum production and wheezing; and 4) hypoxemia based on results of arterial blood gas analysis. Dr. Baker opined that Claimant had a severe impairment with decreased FEV_1, chronic bronchitis, decreased PO_2 and Coal Workers' Pneumoconiosis. This

physician also listed Claimant's degenerative joint disease of the back. He concluded that miner's total disability was due to a combination of cigarette smoking and his coal dust exposure. *Id.*

A diagnosis of pneumoconiosis based on a positive chest x-ray and history of dust exposure alone is not a well-documented and reasoned opinion. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Benefits Review Board permits discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-1405 (1985)). Acknowledging that Dr. Baker performed other physical and objective testing, he listed that he expressly relied on Claimant's positive x-ray and coal dust exposure for his clinical determination of pneumoconiosis. However, the x-ray he relied upon was re-read as negative by a higher qualified physician. Moreover, he failed to state how results from his other objective testing might have impacted his diagnosis of pneumoconiosis. As Dr. Baker does not indicate any other reasons for his diagnosis of clinical pneumoconiosis beyond the x-ray and exposure history, I find his diagnosis of clinical pneumoconiosis neither well-documented nor well-reasoned.

As discussed, legal pneumoconiosis includes any chronic lung disease or impairment arising out of coal mine employment. Dr. Baker diagnosed Claimant with COPD, or legal pneumoconiosis, based on the qualifying results of a pulmonary function study. He related this condition to coal dust exposure and cigarette smoking. Furthermore, Dr. Mettu validated the study. *Id.* I find this portion of Dr. Baker's diagnosis of legal pneumoconiosis well-reasoned and well-documented. *See Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.)

The Board has held that chronic bronchitis falls within the definition of legal pneumoconiosis if it is related to claimant's coal mine employment. *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134, 1-139 (1999). Dr. Baker's diagnosis of chronic bronchitis was based on history. (DX 13). He opined that the etiology of Claimant's chronic bronchitis was based on cigarette smoking and coal dust exposure. *Id.* Dr. Baker failed to provide objective data to support his opinion. In addition, Dr. Baker failed to explain how his physical findings and symptomatology were supportive of a finding of chronic

bronchitis. Thus, I find this portion of his opinion regarding legal pneumoconiosis unreasoned and give it little weight.

Dr. Baker's other diagnosis of legal pneumoconiosis, i.e., hypoxemia, was based on Claimant's non-qualifying blood gas analysis. The etiology of the hypoxemia was history of smoking and coal dust exposure. (DX 13). Legal pneumoconiosis is defined as any chronic lung disease or impairment arising out of coal mine employment. § 718.201(a). Dr. Baker's diagnosis of hypoxemia is inadequate to determine legal pneumoconiosis under the regulations. I find this portion of his opinion regarding legal pneumoconiosis is not well-reasoned, and I give it little weight.[5]

Dr. J. Randolph Forehand, a Pediatric Specialist and Board-certified in the area of Allergy and Immunology, physically examined Claimant on August 25, 2004. (CX 2). His medical workup included a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. Dr. Forehand recorded that Claimant worked in underground coal mine employment for twenty-three years and smoked for four years, quitting in 1974. His report stated that Claimant suffers from shortness of breath, dyspnea on exertion, nighttime wheezing, a productive cough, and difficulty sleeping due to his breathing problems. A chest examination showed "reticulonodular changes at the bases." The EKG was normal. Claimant's pulmonary function study showed an obstructive defect

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[5] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found of Dr. Baker's opinion unreasoned because he failed to explain how his physical findings and symptomatology were supportive of his finding of clinical pneumoconiosis and two of his three diagnoses of legal pneumoconiosis. However, even if all Dr. Baker's opinions were well-reasoned and well-documented, the outcome of this case would not change. First, Claimant could not establish pneumoconiosis by a preponderance of the evidence pursuant to § 718.202(a)(1-4), or that he was totally disabled due to pneumoconiosis. Therefore, I find that remand of this case would be futile. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see, e.g., Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

and his arterial blood gas test produced results indicative of arterial hypoxemia. This doctor also recorded Claimant's family and medical histories. Dr. Forehand diagnosed coal workers' pneumoconiosis and believed that Claimant was totally and permanently disabled from a "work-limiting respiratory impairment" which would prevent Claimant from returning to his last coal mining job. Although Dr. Forehand described the patient's history and test results, in detail, he did not provide a reasoned basis for his diagnosis. In a subsequent letter dated September 15, 2005, Dr. Forehand stated that the basis for Claimant's totally disabled respiratory impairment was his "23 years in underground coal mining," and he found no evidence that his "four years" of smoking cigarettes "made any significant contribution" to his respiratory impairment. *Id.*

Because Dr. Forehand failed to explain the reasons for his diagnosis of clinical pneumoconiosis, and because he based his diagnosis of pneumoconiosis on a smoking history that is questionable in the record, I find his report neither well-documented nor well-reasoned. Therefore, I find his report entitled to little probative weight.

Dr. David M. Rosenberg, Board-certified in Pulmonary Diseases, Occupational Medicine, and a B-reader, conducted a physical examination of Claimant on August 11, 2004, and completed a report on August 31, 2004 and an addendum to his medical report on June 6, 2006. (EX 1, 5). His complete medical workup included a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. He recorded that Claimant worked in coal mine employment, all underground, for twenty-three years. Claimant reported that he smoked for about three years, quitting thirty years prior. Dr. Rosenberg noted that Claimant suffers from shortness of breath with exertion, sputum production, wheezing, and difficulty sleeping because of his breathing problem. This physician noted the patient's use of oxygen twenty-four hours a day and the various medications he was taking. In Dr. Rosenberg's opinion, the chest x-ray and CAT scan he had ordered the date of the examination did not reveal "micronodularity associated with past coal dust exposure." Also, the doctor did not hear "chronic rales." Claimant's TLC was normal and his diffusing capacity was also normal. Based on this information, Dr. Rosenberg did not believe Claimant had the interstitial form of coal workers' pneumoconiosis.

From a functional perspective, Dr. Rosenberg believed that Claimant was disabled secondary to COPD from performing his previous coal mining job or other similarly arduous types of

labor. However, he did not believe the cause of the impairment was coal workers' pneumoconiosis or any lung disease related to Claimant's exposure to coal dust. Rather, he explained that, based on physiologic findings Claimant's disability related to other factors, "probably asthma with remodeling of the airways, leading to COPD formation." In a subsequent deposition, Dr. Rosenberg expounded upon his rationale for finding that pneumoconiosis did not cause Claimant's disability:

> When one looks at the characteristics of obstruction that is found in a given individual many times the characteristics can be utilized to determine the cause of the obstruction in a given miner and that's what I've done here. And when one looks at the pattern of obstruction seen in Mr. _____ [Claimant], one can appreciate this pattern of obstruction. Although he has obstruction, the pattern he displays is not that which one would expect in relationship to coal mine dust exposure.

(EX 4).

Dr. Rosenberg referred to several studies that supported his belief and attached these studies to his deposition. (EX 4). The doctor further stated that Claimant had a "marked bronchodilator response with improvement," which is not what is usually expected with obstructive lung disease that is related to coal mine dust exposure. Finally, Dr. Rosenberg explained, as follows, his rationale for believing that Claimant had developed "remodeling of his airways" which was "really what caused his disabling COPD":

> When one has chronic asthma, what one can develop is that there's chronic inflammation. What asthma represents is chronic inflammation occurring within the airways of the lungs. With our treatments for asthma, we hope that one can suppress that inflammation in the airways. If the inflammation is not suppressed, however, that inflammation leads to scar tissue formation within the area where the inflammation is occurring, in this case within the airways, and this leads to scarring around the airways such that the opening is narrowed, and one develops the significant obstructive lung disease on a chronic basis in this chronic condition of remodeling related to asthma.

Id. His final conclusion was that Claimant had no medical or legal pneumoconiosis.

Dr. Rosenberg was deposed for a second time on June 19, 2006. (EX 5). Dr. Rosenberg testified that based on his review of additional medical opinions by Dr. Forehand, Dr. Chaney, and all other medical opinions that were generated through June of 2006, and are of record, Dr. Rosenberg reported that his original opinions about Claimant's respiratory condition were unchanged. (EX 2, 3, 5). For the reasons discussed above, I find Dr. Rosenberg's report well-reasoned and well-documented.

Dr. Gregory Fino, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, completed a consultative report on August 1, 2005, and two addenda dated, December 6, 2005, and June 7, 2006, and a deposition dated June 19, 2006, regarding Claimant's pulmonary condition based on his review of all medical opinions and test results of record. (EX 6-9). This physician initially noted a coal mining history of twenty-three years and a smoking history of approximately twenty years, quitting in 1964. (Ex 6). Based on the information described in the various reports, Dr. Fino concluded that Claimant suffered from a disabling obstructive impairment consistent with emphysema, but had "no doubt" that Claimant's condition and disability were not due to the inhalation of coal dust. He referred to four studies that discussed the relationship and association of coal mine dust to emphysema. Based on these studies, Dr. Fino's review of the CAT scan and x-rays, his review of Claimant's symptoms and his review of the objective pulmonary function tests, he found the evidence insufficient to attribute Claimant's emphysema to coal dust. (EX 6-9). In his deposition, Dr. Fino testified that he agreed with Dr. Rosenberg's assessment in that he believed Claimant had a "hyperactive airways disease," which he stated was a "fancy term for asthma that has resulted in some fixed airway obstruction." (EX 9). Dr. Fino also admitted that the record was unclear surrounding Claimant's smoking history. However, even assuming Claimant was a non-smoker for many years, Dr. Fino believed that Claimant's respiratory condition, being a type of asthma, was neither caused, nor aggravated by the inhalation of coal mine dust and that he had developed an "airway remodeling that occurs in 10 to 15 percent of asthmatics." *Id.* For the reasons stated, I find Dr. Fino's opinion is well-reasoned and well-documented.

The record contains a CT scan taken on August 11, 2004, and read by Dr. Halbert, a Board-certified radiologist and B-reader.

(EX 10). Dr. Halbert found no nodular opacities to suggest the presence of coal workers' pneumoconiosis.

Hospital Records and Treatment Notes:

The regulations provide that "[n]otwithstanding the limitations of paragraphs (a)(2) and (a)(3) of this section, any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." § 725.414(a)(4).

The record contains hospitalization records and progress notes, a majority of which were completed by the Claimant's treating physician, Dr. George Chaney. (EX 12; CX 1, 3). These notes show that Claimant visited Dr. Chaney about every three months, on average, but sometimes he saw this physician more often, from April of 1999 through February of 2006. From Claimant's first visit through December of 2005, Dr. Chaney consistently diagnosed COPD, bronchitis, and shortness of breath. A few times, the doctor also listed sinusitis. Dr. Chaney frequently listed "other" medical problems, but did not specify the nature of those other problems. Clinical pneumoconiosis or "coal workers' pneumoconiosis" is never listed. In October of 2002, Dr. Chaney reported Claimant to be a "former smoker," but from January of 2003 through June of 2006, this physician indicated on his progress forms that the Claimant was a "current" smoker. This doctor prescribed several medications for the patient's breathing problem. *Id.*

On June 17, 2005, Claimant was hospitalized with a complaint of shortness of breath. (EX 12). Dr. J. Dustin Chaney saw him and determined that he had the following: "1. [a]cute acquired pneumonia[,] 2. [c]hronic obstructive pulmonary disease [and] 3. "[o]ther medical problems." *Id.* Dr. George Chaney completed the patient's discharge report on June 20, 2005, finding pneumonia, COPD, hypertension, and bronchitis. Claimant was again admitted for shortness of breath on August 9, 2005. *Id.* Dr. Chaney's impression at that time was: "1. [l]ong-standing chronic obstructive pulmonary disease with chronic bronchitis; 2. [h]istory of bronchiectasis, on home oxygen; [and] 3. [h]istory of chronic tobacco abuse." In December 2005, Claimant was hospitalized with an exacerbation of his COPD and bronchitis. Upon discharge December 15, 2005, Dr. Chaney's impression was: "1. [a]cute exacerbation of chronic bronchitis with underlying chronic obstructive pulmonary disease[;] 2. [h]ypokalemia, which will be replaced[; and] 3. [o]ther medical

problems as delineate [sic] in the chart." On February 7, 2006, Claimant was, once again, admitted for shortness of breath. Upon discharge, Dr. George Chaney's diagnoses included: 1) COPD exacerbation with acute bronchitis; 2) hypokalemia; and 3) hypertension.

I find that the Claimant's hospital and treatment records contain no reasoned diagnosis of clinical or legal pneumoconiosis. Furthermore, the hospital records do not relate the Miner's pulmonary diseases to his coal mine employment, and, thus, none of these diagnoses constitute legal pneumoconiosis.

Based on these medical opinions and assigning the greatest probative weight to the opinions of Drs. Rosenberg and Fino for the reasons provided, above, I find that Claimant has not established the existence of pneumoconiosis per § 718.202(a)(4). Because the existence of pneumoconiosis is the threshold issue in any claim for black lung benefits under the Act, entitlement to benefits under the Act is not established.

Full Review: Pneumoconiosis:

Claimant's only reviewable previous claim was filed on May 21, 1973. (DX 1). The medical evidence in that claim predates 1980. The Board has held that it is proper to afford the results of recent medical testing more weight over earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the evidence in the prior claim is so remote in time, some documents are illegible, and parts of some documents are apparently missing, I give little or no weight to the old evidence. In weighing the evidence, I give great weight to the evidence in the current claim and adhere to my findings that Claimant has failed to prove by a preponderance of the evidence pneumoconiosis under § 718.202(a)(1-4).

Causation of Pneumoconiosis:

Once pneumoconiosis has been established, the burden is upon Claimant to demonstrate by a preponderance of the evidence

that the pneumoconiosis arose out of the Claimant's coal mine employment. § 718.203(b). However, because pneumoconiosis was not established this is a moot issue.

Total Disability:

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987). Furthermore, Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[6] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[7] or MVV[8] values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B. The record consists of four newly submitted pulmonary function studies. (DX 13, 15; CX 2; EX 1). All of these studies produced qualifying values

[6] Forced expiratory volume in one second.

[7] Forced vital capacity.

[8] Maximum voluntary ventilation.

under the regulations.[9] Thus, I find the pulmonary function study evidence of record establishes total disability under subsection (b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following § 718 of the regulations. Four newly offered studies have been entered into the record. (DX 13, 16; CX 2; EX 1). None of these studies produced qualifying values. Therefore, I find that the blood gas study evidence of record does not establish total disability under subsection (b)(2)(ii) by a preponderance of the evidence.

Total disability under § 718.204(b)(2)(iii) is inapplicable because Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), § 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work.

Drs. Baker, Fino, Rosenberg and Forehand all believed that Claimant was disabled from returning to his former coal mine work, from a respiratory standpoint. Dr. Chaney did not directly address this issue. Overall, these medical opinions weigh in favor of finding total disability under § 718.204(b)(2)(iv). Weighing these opinions together with the qualifying pulmonary function studies, and the non-qualifying blood gas studies, I find that Claimant has established total disability under § 718.204(b)(2) by a preponderance of the evidence.

[9] The fact finder must resolve conflicting heights of the Claimant recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). A majority of these studies measure Claimant at 69 inches; therefore, I find Claimant's height to be 69 inches.

Overall Total Disability Finding:

Upon consideration of all of the evidence of record, Claimant has established, by a preponderance of the evidence, total disability. I continue to place greater weight on the newly submitted evidence. Accordingly, I find Claimant has established total disability under the provisions of § 718.204(b).

Full Review: Total Disability Due to Pneumoconiosis

The regulations state that a claimant "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis ... is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." § 718.204(c)(1). Pneumoconiosis is considered a "substantially contributing cause" of the claimant's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1).

In interpreting this requirement, the United States Court of Appeals for the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). Claimant has established total disability, Claimant has failed to prove total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2). While Drs. Forehand and Baker opined Claimant was totally disabled due to pneumoconiosis, I found that these opinions were not well-reasoned or sufficiently documented. The reasoned reports by Drs. Fino and Rosenberg specifically expressed that Claimant's respiratory impairment was not caused by his past exposure to coal dust. Dr. Chaney did not address the etiology of Claimant's pulmonary condition or attribute it to any specific source, notwithstanding his advice to Claimant to avoid smoking and passive smoke. Therefore, assigning greater probative weight to the opinions of Drs. Fino and Rosenberg over the opinions of Drs. Baker and Forehand, I find that Claimant has failed to establish total disability due to pneumoconiosis by a

preponderance of the evidence or a change in condition from the last prior denial in regard to this finding. In weighing the prior evidence as discussed, I adhere to my finding that Claimant has failed to prove, by preponderance, that his disability was due to pneumoconiosis.

Entitlement:

As Claimant has failed to establish pneumoconiosis or total disability due to pneumoconiosis, I find that he is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any attorney's fees to Claimant for legal services rendered in pursuit of benefits.

ORDER

It is thereby ORDERED that the claim of C.W. for benefits is hereby DENIED.

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LARRY S. MERCK
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to § 725.479(a).